STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095039	A. BUILDING UNITED MEDICAL NURSING CENTER B. WING	01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED MEDICAL NURSING HOME	1310 SOUTHERN AVENUE, SE, SUITE 200 WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code recertification inspection was conducted on January 19, 2012. The following deficiencies are based on observation and review of records.	K 000	**1 – 3. Plan of Correction** The Director of Facilities Management reviewed the findings cited in the Statement of Deficiencies. Each observed penetration was sealed. **Prevention of Future Occurrences** The Environment of Care Rounding Schedule will be reviewed and revised to ensure regularly scheduled environment of care rounds are conducted to identify environmental deficiencies. Included will be observations to assess for the above the ceiling penetrations. Standard Operating Procedures will be followed whereby penetrations will be sealed when work is done above the ceiling. Any identified deficiencies will be incorporated into the building maintenance program. **Performance Monitoring** The EOC Walking Rounds tool will be used to monitor. Compliance results will be reported to the QA and PI Committees. **Responsible Individual(s)** The Administrator and Director of Nursing.	3/15/2012
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection it was determined that the walls above ceiling tiles were not secured to prevent the passage of smoke in the event of a fire in eight (8) of 32 observations. These findings were observed in the presence of the Assistant Director of Maintenance. The findings include:	K 017		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Donna Allen Williamson LNHA	LNHA	3.12.12.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 017	Continued From page 1 1. A large penetration, approximately 4 feet x 5 inches, was observed above the 6th floor hallway window near room 601 in one (1) of 12 observations between 9:40 AM and 10:30 AM on January 19, 2012. 2. Penetrations were observed above ceiling tiles near room 720; two (2) penetrations were observed near room 720 on the left side and three (3) penetrations were observed on the right side of room 720 in five (5) of 10 observations between 9:50 AM and 10:25 AM on January 19, 2012. 3. Two (2) penetrations were observed above ceiling tiles near the entrance to the Clean Utility Room in two (2) of 10 observations at approximately 10:00 AM on January 19, 2012.	K 017		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	**1 - 2 Plan of Correction** The Director of Facilities Management reviewed the findings cited in the Statement of Deficiencies. Each identified deficiency was fully addressed. The chains were removed from the entrance doors and staff was educated on not maintaining the doors in a propped open position. The door closures for Room #726 and room # 744 were adjusted to ensure positive latching. **Prevention of Future Occurrences** The Environment of Care Rounding Schedule will be reviewed and revised to ensure regularly scheduled environment of care rounds are conducted to identify environmental deficiencies. Included will be observations to assess for properly closed doors and functioning door latches.	

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	095039	A. BUILDING 7W - UNITED MEDICAL B. WING	01/19/2012

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations during the Life Safety Code Inspection it was determined that doors located at the entrance to the Dining Room were propped open with a chair in two (2) of two (2) observations and entrance doors to residents rooms failed to close and latch into frames in two (2) of 10 observations. The findings include: 1. Entrance doors to the 6th Floor Residents' Dining Room were propped open with high back chairs, which would prevent doors from closing in the event of an emergency in two (2) of two (2) observations at 10:05 AM on January 19, 2012. 2. Entrance doors to resident ' s rooms #726 and #744 failed to close and latch into frames without assistance when tested in two (2) of ten observations on January 19, 2012. These findings were observed in the presence of the Assistant Maintenance Director.	K 018	Any identified deficiencies will be incorporated into the building maintenance program. Facilities/Maintenance staff will pursue having the entrance doors magnetized. **Performance Monitoring** The EOC Walking Rounds tool will be used to monitor. Compliance results will be reported to the QA and PI Committees. **Responsible Individual(s)** The Administrator and Director of Nursing.	3/15/2012
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by:	K 048	**Plan of Correction** The Director of Facilities Management reviewed the findings cited in the Statement of Deficiencies. Each identified deficiency was fully addressed. New evacuation routes with accompanying legends were posted in the hallway on the 6th and 7th floors adjacent to the Nurse's Station, and near room #627 to direct individuals to the nearest exit in the	

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K 048	Continued From page 3 Based on observations during the Life Safety Code Inspection it was determined that evacuation drawings on walls in the hallways were not descriptive to direct residents and staff to the nearest egress point in the event of a fire in three (3) of 12 observations. The findings include: Evacuation routes posted in the hallway on the 6th and 7th floors adjacent to the Nurses Stations and near Room 627 lacked a complete legend with information to direct staff and residents to the nearest exit in the event of a fire, such as the location "You are Here, Pull Stations and Fire Extinguishers" in three (3) of 12 observations on January 19, 2012. These findings were observed in the presence of the Assistant Director of Maintenance Services.	K 048	event of a fire. **Prevention of Future Occurrences** The Environment of Care Rounding Schedule will be reviewed and revised to ensure regularly scheduled environment of care rounds are conducted to identify environmental deficiencies. Included will be descriptive evacuation signage. Any identified deficiencies will be incorporated into the building maintenance program. **Performance Monitoring** The EOC Walking Rounds tool will be used to monitor. Compliance results will be reported to the QA and PI Committees. **Responsible Individual(s)** The Administrator and Director of Nursing.	3/15/2012